

# HARDSHIP CONSIDERATIONS

## **Instructions**

Please read all questions carefully. All “yes” answers must include a detailed explanation and appropriate documentation (attach additional pages as needed). Return the completed form to the Behavioral Health Provider within 30 days of the initial ineligibility determination. The Division of Behavioral Health will make a determination on eligibility within 30 days of receiving the completed form and necessary verifications from the Behavioral Health Provider.

## **Personal Information**

(Please Print)

CID #: \_\_\_\_\_

Consumer Name: \_\_\_\_\_  
(First) (MI) (Last)

Address: \_\_\_\_\_ Ph. #: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Parent/Guardian or Representative (if applicable): \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

☐ **YES** ☐ **NO** Are you responsible for the care of extended family members or other household members? If yes, please list whose care you are responsible for and provide documentation of expenses.

\_\_\_\_\_  
\_\_\_\_\_

☐ **YES** ☐ **NO** Do you have debt from prior chemical dependency treatments, illness, or other out of pocket medical expenses? For gambling services only, identify gambling losses/debt. If yes, please include bills or receipts of such debt and/or expenses.

\_\_\_\_\_  
\_\_\_\_\_

☐ **YES** ☐ **NO** Have you had any unforeseen/uncontrollable expenses (other than medical expenses)? If yes, please give a detailed description of the expenses and provide bills/receipts.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ **YES** ☐ **NO** Are there two or more persons in your household who have disabilities or are chemically dependent? If yes, please list each individual who has a disability, or is chemically dependent, and what their specific disability is. Also provide documentation of expenses that result from such disabilities or expenses that result from chemical dependency related problems/treatment.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ **YES** ☐ **NO** Do you or another household member have more than one disability? If yes, please list the individual and the specific disabilities. Also provide documentation of expenses that result from such disabilities.

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\_\_\_\_\_

☐ **YES** ☐ **NO** Do you have extraordinary housing or costs of care (e.g., paying rent during hospitalization)? If yes, please describe and provide documentation.

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☐ **YES** ☐ **NO** Do you have excessive transportation costs? If yes, please describe and provide documentation.

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☐ **YES** ☐ **NO** Do you have other expenses/circumstances that would make paying for mental health or chemical dependency services an undue financial stress (e.g., expenses incurred while gambling)? If yes, please describe and provide documentation.

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☐ **YES** ☐ **NO** Are you a person 18 years of age or older with a mental health and/or chemical dependency diagnosis living with a parent or sibling because no other satisfactory living arrangement is available? If so, enter parent or siblings income below so it may be deducted from the Means 101.

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I hereby attest that this information is true and correct. I understand that any false statements that I make and any failure on my part to report change in circumstance which affect my eligibility could result in my being responsible for reimbursement of services provided and/or ineligibility for services.

Signature (Consumer or Parent/Guardian) \_\_\_\_\_ Date \_\_\_\_\_

<div>The Department of Social Services Division of Behavioral Health Kneip Building c/o 700 Governors Drive Pierre, SD 57501 (605) 773-3123 or 1-855-878-6057</div>	<b>Division of Behavioral Health Use Only</b>	
	<input type="checkbox"/> Eligible	<input type="checkbox"/> Ineligible
	Date Reviewed:	
	Signature of Reviewer:	